

**JUDGE RAMOS**  
**UNITED STATES DISTRICT COURT**  
**SOUTHERN DISTRICT OF NEW YORK**

**12 CV 5886**

**ALEXANDRA GARCIA, as Parent and**  
**Natural Guardian o/b/o S.S., an Infant,**

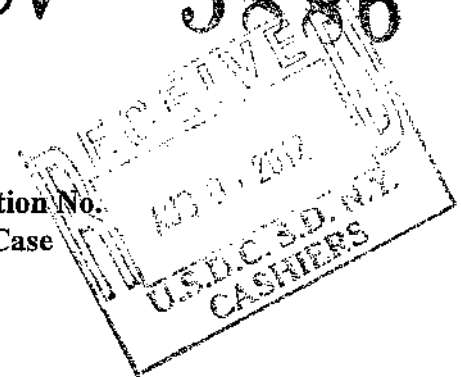
**Plaintiff,**

**- against -**

**MICHAEL J. ASTRUE, as**  
**Commissioner of Social Security,**

**Defendant.**

Civil Action No.  
ECF Case



**COMPLAINT**

**PRELIMINARY STATEMENT**

1. This action is authorized by Section 205(g) and 1383(c)(3) of the Social Security Act, 42 U.S.C. 405(g), to review a final decision of the Commissioner of Social Security.
2. Venue lies in the Southern District of New York pursuant to 42 U.S.C. §405(g) based on the residency of the plaintiff.
3. Plaintiff challenges the determination of the Commissioner that S.S., an infant, was ineligible for Supplemental Security Income ("SSI") benefits effective July 9, 2008 within the meaning of Title XVI of the Act.
4. Plaintiff contends that the Commissioner's determination was arbitrary and capricious, not supported by substantial evidence and contrary to law.

**PARTIES**

5. Plaintiff Alexandra Garcia, is the mother and natural guardian of S.S., an infant. They reside in the Bronx, New York.

6. Defendant Commissioner of Social Security is responsible for the administration of Title XVI of the Act, and the determination of claims and payment of benefits thereunder.

**FACTS**

7. S.S. was born in 1999, and is presently 13 years old.

8. S.S. is a child who has been diagnosed with Attention Deficit-Hyperactivity Disorder, Inattentive Type ("ADHD"), borderline intellectual functioning, a learning disability, severe receptive/expressive language delays tested at two to three standard deviations below the mean, and clinical obesity.

9. During the disability period in issue S.S. was treated for ADHD with medication therapy (Concerta 36 mg and Adderall XR 20 mg) by the Children's Neuroscience Center of St. Luke's-Roosevelt Hospital Center.

10. During the disability period in issue S.S. has been in special education placed in successively restrictive classroom settings, with speech/language therapy and counseling as related services.

11. In standardized testing S.S., then age 10-1, attained grade-equivalent scores of 2.0 in word reading, 1.9 in reading comprehension, and 1.5 in decoding – scores which demonstrated regression from her performance on the same battery of tests administered one year earlier.

12. On July 9, 2008, when S.S. was nine years old, plaintiff applied for SSI benefits on her behalf, and the application was denied.

13. On June 16, 2010, a hearing was held before ALJ John W. Noonan, at which plaintiff and S.S. appeared without counsel.

14. On June 25, 2010, the ALJ issued an unfavorable decision.

15. In his decision, the ALJ found that S.S. had a marked limitation in the domain of health and physical well-being, a finding supported by substantial evidence.

16. In his decision, the ALJ found that S.S. had severe impairments including ADHD, obesity, learning disorder, and speech/language delays.

17. In his decision, the ALJ found that S.S. has limitations in acquiring and using information, attending and completing tasks, interacting and relating with others, and moving about and manipulating objects – but that these limitations were “less than marked.”

18. The plaintiff, through counsel, timely requested review by the Appeals Council, and submitted additional new and material evidence for the administrative record, some of which was accepted as additional evidence, and some of which, with no explanation, was not accepted.

19. By notice dated June 22, 2012, the Appeals Counsel denied review, making the ALJ’s decision the final determination of the Commissioner. A copy of the June 22, 2012 notice is attached hereto as Exhibit A.

20. A notice of the Appeals Council’s denial of review was sent to the plaintiff, but no notice was received by plaintiff’s counsel, who therefore requested the Appeals Council to extend the time for the filing of a district court action.

#### **FIRST LEGAL CLAIM**

21. Since July 9, 2008 and continuously thereafter, S.S. has not engaged in substantial gainful activity.

22. Since July 9, 2008 and continuously thereafter, S.S. has suffered from a medically determinable impairment or combination of impairments which are expected to last for a continuous period of at least 12 months and which result in marked and severe functional limitations.

23. Since July 9, 2008 and continuously thereafter, S.S.'s impairments met or medically or functionally equaled the Listings.

24. The determination of the Commissioner is not supported by substantial evidence, and is arbitrary, capricious and contrary to law.

### **SECOND LEGAL CLAIM**

25. The ALJ failed to adequately develop the administrative record.

26. Upon information and belief, the ALJ reached his unfavorable decision after holding an unreasonably short hearing, with an inadequate inquiry into the severity of S.S.'s impairments—in particular, her diagnosed ADHD severe receptive/expressive language delays.

27. The ALJ issued his unfavorable decision without developing the documentary record of treatment of S.S.'s psychiatric and cognitive impairments, and without seeking opinion evidence from S.S.'s treating physician regarding the severity of these impairments.

### **THIRD LEGAL CLAIM**

28. The ALJ committed legal error by failing to consider and accord appropriate weight to standardized language testing in the record as it impacted S.S.'s limitations in the domains of acquiring and using information and interacting and relating with others.

### **FOURTH LEGAL CLAIM**

29. The ALJ committed legal error by failing to consider the cumulative and interactive effect of S.S.'s multiple impairments—particularly her severe receptive/expressive language delays and her borderline intellectual functioning.

### **FIFTH LEGAL CLAIM**

30. The ALJ committed legal error by failing to adequately assess the effect of S.S.'s severe obesity in the functional domain of moving about and manipulating objects.

**SIXTH LEGAL CLAIM**

31. The Appeals Council erred by failing to add new and material evidence proffered by plaintiff's attorney: i.e., reports from S.S.'s treating physician, Steven M. Wolf, M.D., Children's Neuroscience Center of St. Luke's-Roosevelt Hospital Center, and a pharmacy medication printout covering a three-year span that included most of the disability period in issue. Copies of these documents, with proof of timely transmission to the Appeals Council, are attached hereto as Exhibit B.

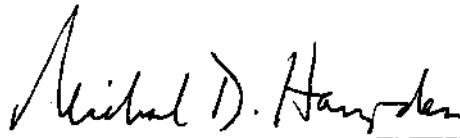
32. The documentary evidence proffered to the Appeals Council should be deemed included in the administrative record herein.

**RELIEF REQUESTED**

WHEREFORE, plaintiff respectfully prays that this Court:

1. Assume jurisdiction of this action;
2. Order that the documents timely proffered to the Appeals Council (Exhibit B) are new and material evidence and will be deemed included in the administrative record;
3. Reverse the Commissioner's decision that S.S. is not disabled within the meaning of Title XVI of the Act, and award SSI benefits effective on and after July 9, 2008;
4. In the alternative, pursuant to Sentence 4 of 42 U.S.C. § 405(g), remand this action for a new administrative proceeding, with the direction that the Commissioner's favorable finding below (S.S. has a marked limitation in the domain of health and physical well-being), is supported by substantial evidence and will not be disturbed upon remand;
5. Award plaintiff reasonable attorney's fees and expenses pursuant to the Equal Access to Justice Act ("EAJA"), 28 U.S.C. §2412(d); and
6. Award such other and further relief as to this Court may seem just and proper.

Dated: New York, New York  
July 30, 2012

A handwritten signature in black ink, reading "Michael D. Hampden". The signature is written in a cursive style with a large, stylized "M" and "H".

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MICHAEL D. HAMPDEN (MDH 2359)  
PARTNERSHIP FOR CHILDREN'S RIGHTS  
Attorney for Plaintiff  
271 Madison Avenue, 17<sup>th</sup> Floor  
New York, New York 10016  
212-683-7999, ext. 226; Fax: 212-683-5544  
mhampden@pfcrr.org

**EXHIBIT A**

**Notice of Appeals Council Denial of Review**

Office of Disability Adjudication  
and Review  
5107 Leesburg Pike  
Falls Church, VA 22041-3255  
Telephone: (877) 670-2722  
Date: June 22, 2012

See Next Page

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XXXXXXXXXX (XXXX-XX-8702)

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additional evidence listed on the enclosed Order of Appeals Council.

We found that this information does not provide a basis for changing the Administrative Law Judge's decision.

### **If You Disagree With Our Action**

If you disagree with our action, you may ask for court review of the Administrative Law Judge's decision by filing a civil action.

If you do not ask for court review, the Administrative Law Judge's decision will be a final decision that can be changed only under special rules.

### **How to File a Civil Action**

You may file a civil action (ask for court review) by filing a complaint in the United States District Court for the judicial district in which you live. The complaint should name the Commissioner of Social Security as the defendant and should include the Social Security number(s) shown at the top of this letter.

You or your representative must deliver copies of your complaint and of the summons issued by the court to the U.S. Attorney for the judicial district where you file your complaint, as provided in rule 4(i) of the Federal Rules of Civil Procedure.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Social Security Administration's Office of the General Counsel that is responsible for the processing and handling of litigation in the particular judicial district in which the complaint is filed. The names, addresses, and jurisdictional responsibilities of these offices are published in the Federal Register (70 FR 73320, December 9, 2005), and are available on-line at the Social Security Administration's Internet site, <http://policy.ssa.gov/poms.nsf/links/0203106020>.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Attorney General of the United States, Washington, DC 20530.

### **Time To File a Civil Action**

- You have 60 days to file a civil action (ask for court review).
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period.
- If you cannot file for court review within 60 days, you may ask the Appeals Council to extend your time to file. You must have a good reason for waiting more than 60 days to ask for court review. You must make the request in writing and give your reason(s) in

See Next Page

S ██████████ ██████████ S ██████████ (██████████-██████████-8702)

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the request.

You must mail your request for more time to the Appeals Council at the address shown at the top of this notice. Please put the Social Security number(s) also shown at the top of this notice on your request. We will send you a letter telling you whether your request for more time has been granted.

## About The Law

The right to court review for claims under Title II (Social Security) is provided for in Section 205(g) of the Social Security Act. This section is also Section 405(g) of Title 42 of the United States Code.

The right to court review for claims under Title XVI (Supplemental Security Income) is provided for in Section 1631(c)(3) of the Social Security Act. This section is also Section 1383(c) of Title 42 of the United States Code.

The rules on filing civil actions are Rules 4(c) and (i) in the Federal Rules of Civil Procedure.

## If You Have Any Questions

If you have any questions, you may call, write, or visit any Social Security office. If you do call or visit an office, please have this notice with you. The telephone number of the local office that serves your area is (877)619-2852. Its address is:

Social Security Admin.  
2720 Jerome Avenue  
Bronx, NY 10468-3522

/s/ Dennis W. Ranker

Dennis W. Ranker  
Appeals Officer

Enclosure: Order of Appeals Council

cc: Michael D. Hampden  
271 Madison Ave.  
17th Floor  
New York, NY 10016

\*0403CIPAL002458\*NOTAF.P.X3.CIPAFP.ODARS.H120622.P61K 00000000000000000000CFP88012062213.1500108200



**EXHIBIT B**

**New and Material Evidence Proffered.  
To Appeals Counsel**

12

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Document Description:	Administrative and Financial Records
Unclassified:	K
Excluded:	K



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Exhibit 7  
ADHD Consultation Sheet, Steven M. Wolf, M.D., Children's Neuroscience Center,  
12/15/08

## CHILDREN'S NEUROSCIENCE CENTER

STEVEN M. WOLF, M.D.

PATTY MCGOLDRICK NP

MAITE LAVEGA, M.D.

## ADHD CONSULTATION SHEET

PATIENT NAME: S. [REDACTED] S. [REDACTED]

D.O.B: \_\_\_\_\_

Age: \_\_\_\_\_

D.O.V: 12-15-09

P.M.D.: \_\_\_\_\_

( ☐ Mail )Dx: ADHD - Inattentive + HyperactiveCurrent Meds: ADHD XR 20mg DT

Side effect:

☐

Wt Loss

☐

Insomnia

☐

Sedation

☐

None

☐

Headache

☐

Sleepiness

☐

Rash

☐

Double vision

☐

Irritability

☐

Appetite

Home issues: sleep dis.School issues: no reports yet since ↑  
Start Bunch Beh

Blood tests: \_\_\_\_\_

Physical examination:

Wt. 158

Ht. \_\_\_\_\_

BP \_\_\_\_\_

MS: ☐

Alert and oriented for person place and time

CN: +/- Nystagmus

☐

BOMI

☐

PERLA

CEREBELLAR:

☐

Dysmetria

☐

Slow/Normal RAM

GAIT:

☒

Stable

☐

Unstable

☐ No change from prior exam.☐

Normal exam.

MOTOR: ☐

Equal Strength

Assessment and Plan: Continue meds  
Rx Bunch Beh  
R 3/2/09 9am☐ Patient was seen and examined with resident.

Children's Neuroscience Center (DDC)  
 St. Luke's-Roosevelt Hospital Center  
 1000 Tenth Avenue - Winston Building - Ground fl.  
 New York, NY 10019

Tel: (212) 523-6230  
 Fax: (212) 523-6241

13  
23

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E. 5) Exceeded max. E-mail size

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Unstable:	N
Sensitive:	N



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### **Exhibit 8**

Child and Adolescent Health Examination Form, North Central Bronx Hospital  
Center, 10/15/07

4-402

CHILD & ADOLESCENT HEALTH EXAMINATION FORM				Please Print Clearly Press Hard		STUDENT ID NUMBER DOSS	
NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE				DEPARTMENT OF EDUCATION		206745721	
TO BE COMPLETED BY PARENT OR GUARDIAN							
Child's Last Name		First Name		Middle Name		Sex	Date of Birth (Month/Day/Year)
285 E 203rd St		S				Female	1/19/99
City/Borough		State	Zip Code	School/Center/Camp Name		District Number	Phone Numbers
Bronx		NY	10465	INTUITIVE			Home: (718) 220-1518
Health Insurance (including Medicaid)?		Parent/Guardian Last Name		First Name		Cell	
Yes		Garcia		Alexandra			
TO BE COMPLETED BY HEALTH CARE PROVIDER							
Birth history (age 0-6 yrs)		Does the child/adolescent have a past or present medical history of the following?					
Uncomplicated		Asthma (check severity and attach MAF/Asthma Action Plan):					
Premature: _____ weeks gestation		Intermittent Mild Persistent Moderate Persistent Severe Persistent					
Complicated by:		If persistent, check all current medication(s):					
Allergies		Inhaled corticosteroid Other controller Quick relief med Oral steroid None					
Drugs (list)		Attention Deficit Hyperactivity Disorder					
Foods (list)		Chronic or recurrent otitis media					
Other (list)		Congenital or acquired heart disorder					
		Developmental/learning problem					
		Diabetes (attach MAF)					
		Orthopedic injury/disability					
		Seizure disorder					
		Speech, hearing, or visual impairment					
		Tuberculosis (latent infection or disease)					
		Other (specify)					
		Medications (attach MAF if in-school medication needed)					
		None Yes (list below)					
		Concerta, melatonin					
		Dietary Restrictions					
		None Yes (list below)					
Explain all checked items above or on addendum							
PHYSICAL EXAMINATION							
Height		Weight		BMI		Head Circumference (age <2 yrs)	
76.5-74		96.39		35.09		139	
Blood Pressure (age >3 yrs)		139/65		General Appearance: well appearing, dextro			
Blood Pressure (age >3 yrs)		139/65		Describe abnormalities: acanthosis			
DEVELOPMENTAL (age 0-6 yrs)		SCREENING TESTS		Tuberculosis			
Within normal limits		Date Done Results		Date Done Results			
If delay suspected, specify below		Blood Lead Level (BLL)		Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school			
Cognitive (e.g., play skills)		Lead Risk Assessment		PPD/Mantoux placed			
Communication/Language		Hearing		PPD/Mantoux read			
Social/Emotional		Pure tone audiometry		Interferon Test			
Adaptive/Self-Help		COAE		Chest x-ray			
Motor		Hemoglobin or Hematocrit (age 9-12 mo)		Vision			
				Acuity Right			
				Acuity Left			
				Strabismus			
IMMUNIZATIONS - DATES							
Hep B							
DTaP/DTaP/DT							
PCV							
Other, specify:							
RECOMMENDATIONS							
Full physical activity Full diet							
Restrictions (specify)							
Follow-up Needed							
Referral(s)							
Other							
Health Care Provider Signature							
Date							
Health Care Provider Name and Degree (and facility Name)							
Provider License No. and State							
National Provider Identifier (NPI)							
Address							
City							
State							
Zip							
Telephone							
Fax							



## NEW ADMISSION EXAMINATION FORM

DEPT. OF HEALTH & MENTAL HYGIENE — DEPT. OF EDUCATION  
Return in 2 Weeks. Please Print Clearly / Press Hard

## HEALTH MESSAGE

STUDENT ID # / OSIS

See Reverse Side

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT LAST NAME <b>S [REDACTED]</b>			FIRST NAME <b>S [REDACTED]</b>			MIDDLE			SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	BIRTHDAY MONTH DAY YEAR <b>09 09 99</b>			RACE/ETHNICITY Check all that apply <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Other		
GUARDIAN LAST NAME <b>Garcia</b>			GUARDIAN FIRST NAME <b>Alexandra</b>			STUDENT ADDRESS <b>2856 203rd St</b>			APT./FL <b>3</b>			TELEPHONE NO. HOME: <b>718 220-1518</b> WORK: ( )			
SCHOOL DISTRICT NUMBER <b>10 10 10</b>			<input type="checkbox"/> Public Elem <input type="checkbox"/> Public H.S. <input type="checkbox"/> Public JHS/MS <input type="checkbox"/> Non-Public			SCHOOL NAME <b>P.S. 54</b>			<input type="checkbox"/> Annex 1 <input type="checkbox"/> Annex 2			Does this child have any form of health insurance, including Medicaid or Child Health Plus? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

If yes to any item, provide:

Does the student have a past or present medical history of the following:

PRES.	PAST	NO	PRES.	PAST	NO	PRES.	PAST	NO	DATE	DETAILS
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> ASTHMA (If present, attach medication administration form)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Diabetes (If present, attach medication administration form)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Speech Problems		
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Hospitalizations		<b>3mo. fever</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Surgery		
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Serious Illness		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Serious Accidents		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Other Problems/Limitations		

PHYSICAL EXAMINATION: HEIGHT **146cm** (%ile) WEIGHT **127** lb (%ile) BMI **( )** (%ile) BLOOD PRESSURE **110/60**

GENERAL APPEARANCE (NUTRITIONAL STATUS): **well appearing, obese**

HE	AS	HE	AS	HE	AS	HE	AS	HE	AS	HE	AS
<input type="checkbox"/>	<input type="checkbox"/>	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	LYMPH NODES	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	BACK
<input type="checkbox"/>	<input type="checkbox"/>	DENTAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	GENITO URINARY	<input type="checkbox"/>	<input type="checkbox"/>	SKIN
<input type="checkbox"/>	<input type="checkbox"/>	NECK	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	NEURO
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	GROSS MOTOR
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	PSYCHO/SOCIAL DEV.
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	LANGUAGE
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	BEHAVIORAL
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	FINE MOTOR

DESCRIBE ABNORMALITIES:

Hearing DATE <b>10/15/07</b> RESULTS <b>(P) F</b>	Vision DATE <b>10/15/07</b>	Right FAR <b>20/40</b> NEAR <b>20/40</b> FUSION <b>(P) F</b>	Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test.
AUDIO/SWEEP <b>10/15/07</b> RESULTS <b>(P) F</b>	Left FAR <b>20/40</b> NEAR <b>20/40</b> COLOR <b>(P) F</b>		
THRESHOLD <b>10/15/07</b> RESULTS <b>(P) F</b>	Both <b>20/40</b> <b>20/40</b>		

TB: Only required for students newly entering the NYC school system in Intermediate/Middle/Junior or High School

MANTOUX DATE <b>6/14/04</b> RESULTS <b>(P) F</b>	BLOOD-BASED TB TEST RESULTS	Chest X-ray	BCG	On INH
(PPD) IMPLANTED <b>6/14/04</b> RESULTS <b>(P) F</b>	Name <b>(P) F</b>	DATE <b>6/14/04</b>	DATE <b>6/14/04</b>	DATE <b>6/14/04</b>
READ <b>6/14/04</b> RESULTS <b>(P) F</b>	Date <b>6/14/04</b>	RESULTS <b>(P) F</b>	RESULTS <b>(P) F</b>	RESULTS <b>(P) F</b>

LEAD: Risk Assessment	DATE DONE <b>10/15/07</b>	RESULTS <b>(P) F</b>	If at risk, do venous lead screening	DATE DONE <b>10/15/07</b>	RESULTS <b>(P) F</b>
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IMMUNIZATION — DATES Citywide Immunization Registry no. **10 10 10**

DPT/DTaP or DT or Td <b>4/27/99 6/29/99 9/10/99 6/12/00 6/14/04 11</b>	IPV/OPV <b>4/27/99 6/29/99 6/12/00 6/14/04 11</b>	Hepatitis B <b>2/5/99 6/29/99 6/20/00 2/10/00 7/15/03</b>	HIB <b>2/5/99 6/29/99 6/20/00 2/10/00 10/15/07</b>	MMR <b>2/10/00 7/15/03</b>	VZV <b>2/10/00 10/15/07</b>	Other <b>11 11 11</b>
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May provide copy of CIR print out in lieu of completing this section. Must complete CIR Number above.

DIAGNOSES — If Asthma, indicate severity	DATE OF EXAM: <b>10/15/07</b>	DO NOT ONLY PROVIDER ID: <b>10 10 10</b>
<input checked="" type="checkbox"/> Well Child V202 ICD CODE	Physician Signature: <b>H. Lawsky</b>	TYPE OF EXAMINATION
1. <b>Obesity</b>	Physician Name (Print): <b>H. Lawsky</b>	<input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year's
2. <b></b>	Address: <b>2856 203rd St</b>	Comments
3. <b></b>	Telephone: <b>718 220-1518</b>	REVIEWER
RECOMMENDATIONS/REFERRALS	Facility: <b>North Central Bronx Hospital</b>	DATE
<input checked="" type="checkbox"/> FULL PHYSICAL ACTIVITY <input type="checkbox"/> RESTRICTIONS	Facility: <b>Pediatric Outpatient Services</b>	DATE
Specify limitations and/or special alerts (i.e., allergies, medications, precautions)	Facility: <b>10461</b>	DATE
	Facility: <b>10461</b>	DATE

\* \* \* Communication Result Report ( Jun. 13. 2012 11:26AM ) \* \* \*

1)  
2)

Date/Time: Jun. 13. 2012 11:18AM

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## Reason for error

E. 1) Hang up or line fail  
E. 3) No answer  
E. 5) Exceeded max. E-mail size

E. 2) Busy  
E. 4) No facsimile connection



PARTNERSHIP FOR CHILDREN'S RIGHTS  
171 MADISON AVENUE • 17<sup>TH</sup> FLOOR • NEW YORK, NY 10016  
TELEPHONE (212) 683-7999 • FAX (212) 683-5544

## FAX COVER SHEET

TO: Appeals Council FAX: 703-605-7391

FROM: MICHAEL D. HAMPTON, voice tel. no. 212-683-7999, ext. 226

DATE: 6/13/12 PAGES: 5 (including cover)

RE: ~~SECRET~~ ~~SECRET~~

~~SECRET~~ - 8702

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PARTNERSHIP FOR  
CHILDREN'S RIGHTS

June 13, 2012

Appeals Council  
Social Security Administration  
Office of Hearings and Appeals  
5107 Leesburg Pike  
Falls Church, VA 22041-3255  
Attn: Branch 9, Suite 905

Re: ~~XXXXXXXXXX~~ ~~XXXXXXXXXX~~  
~~XXXXXXXXXX~~-8702

Dear Administrative Appeals Judges:

On July 26, 2010, I wrote to you on behalf of Alexandra Garcia, the parent of the infant claimant ~~XXXXXXXXXX~~. ~~XXXXXXXXXX~~, requesting review of the unfavorable June 25, 2010 Administrative Law Judge decision, affirming the denial of the SSI application made on behalf of the child.

On January 10, 2012, I sent a letter asking that the case be designated "Critical" since 18 months had passed since the request for review.

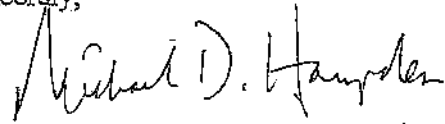
On February 23, 2012 you sent me notice that the case would be decided shortly, and affording me 25 days to submit a statement in support of the appeal and new evidence.

On March 19, 2012 I submitted the claimant's statement in support of the appeal and new evidence.

Since the Appeals Council's decision has not yet been issued, I am enclosing herewith additional evidence to be added to the administrative record that is both new and material: i.e., a 2-page pharmacy printout of ~~XXXXXXXXXX~~'s medications from November 4, 2008 to the present. This exhibit establishes that throughout the disability period in issue, and to the present day, ~~XXXXXXXXXX~~ has been receiving prescribed medications for the treatment of her ADHD.

Three more months have now elapsed and no decision has been issued. Please give this case your priority since nearly four years have elapsed since the SSI application, and nearly two years have elapsed since the request for review by the Appeals Council was made.

Sincerely,

A handwritten signature in black ink, reading "Michael D. Hampden". The signature is written in a cursive style with a large, stylized "M" and "H".

Michael D. Hampden  
Attorney for Claimant

BY FAX AT 703-605-7391

cc:

Alexandra Garcia  
285 East 203<sup>rd</sup> Street, #3  
Bronx, NY 10458  
(By First Class Mail)

# LEROY PHARMACY II, LLC

245 EAST 198TH STREET BRONX, NY 10458  
Phone : 718-220-7600 Fax : 718-220-7618

Page 1 of 2

## Patient Profile

Date Range: 1/1/2008 - 6/13/2012

Name : **S. [REDACTED], S. [REDACTED]**  
Address : 285 EAST 203RD 3 BRONX, NY 10458  
Phone # : 718-220-1518 DOB : **08-08-1989**  
Allergy : No Known Allergies

I certify that this form is correct and I have received the drugs below.

X

Date	Rx #	Drug Name	Quantity	Days	Ref	NDC #	RPh	Prescriber Name	Patient Paid	Total
04-2008	289830	ADDERALL XR 10MG CAP	30	30	0	54092-0383-01	HP	TALBOTT, MAITE	0.00	146.14
04-2008	294902	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	146.14
03-2008	299145	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	146.14
03-2009	304691	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	174.67
06-2009	310700	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	174.67
02-2009	315585	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	174.67
07-2009	321977	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	174.67
08-2009	322138	AMOXICILLIN 400MG/5ML	150	10	0	00781-5157-57	KMS	DUFFEY, ROBERT	0.00	14.31
06-2009	325550	IBUPROFEN CHILDREN'S 1	120	2	2	00904-5309-20	KMS	SEIDLER-LISS, ALI	0.00	16.26
06-2009	325551	GEN AUGMENTIN 400/5 SU	200	10	0	66666-1012-02	KMS	SEIDLER-LISS, ALI	0.00	48.56
08-2009	325551	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	174.67
10-2009	334202	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	191.79
07-2009	325550	IBUPROFEN CHILDREN'S 1	120	2	1	00904-5309-20	KMS	SEIDLER-LISS, ALI	0.00	16.26
03-2009	343160	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	191.79
12-2009	351231	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	184.25
10-2009	357120	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	184.25
08-2009	360145	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	184.25
07-2010	366435	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	184.25
06-2010	371690	AMOXICILLIN 875 MG TABL	20	10	0	00781-5061-20	KMS	FRANCIS, MITZIE *	0.00	14.00
04-2010	373797	ADDERALL XR 20MG CAP	30	30	0	54092-0387-01	KMS	WOLF, STEVERT M	0.00	184.25
15-2010	380772	CONCERTA 18MG TAB	30	30	0	50458-0585-01	KMS	WOLF, STEVERT M	0.00	137.25
07-2010	385292	CLINDAMYCIN 300MG CAP	30	10	0	59762-5010-02	KMS	PINEDO, VINCENT	0.00	31.76
07-2010	385293	IBUPROFEN 400 MG TAB	30	7	0	55111-0682-05	KMS	PINEDO, VINCENT	0.00	5.54
12-2010	388354	CONCERTA 18MG TAB	30	30	0	50458-0585-01	KMS	WOLF, STEVERT M	0.00	137.25
03-2010	390768	NYSTATIN CREAM 15GM	15	10	1	00168-0054-15	KMS	LAWSKY-SCHEER,	0.00	5.58
11-2010	390768	NYSTATIN CREAM 15GM	15	10	0	00168-0054-15	KMS	LAWSKY-SCHEER,	0.00	5.58
17-2010	393622	FLUCONAZOLE 100 MG TA	14	14	0	63304-0804-01	KMS	SEIDLER-LISS, ALI	0.00	8.68
17-2010	393623	CLOTTRIMAZOLE 1 % CREA	30	15	0	45802-0434-11	KMS	SEIDLER-LISS, ALI	0.00	5.78
01-2010	396299	CONCERTA 18MG TAB	30	30	0	50458-0585-01	KMS	WOLF, STEVERT M	0.00	137.25
15-2010	404629	CONCERTA 36MG TAB	30	30	0	50458-0585-01	KMS	MCGOLDRICK, PAT	0.00	144.92
23-2010	411156	CONCERTA 36MG TAB	30	30	0	50458-0585-01	KMS	MCGOLDRICK, PAT	0.00	144.92
29-2010	418064	CONCERTA 36MG TAB	30	30	0	50458-0585-01	HP	MCGOLDRICK, PAT	0.00	144.92
29-2010	418091	GEN PERIDEX MOUTH WA	473	20	0	00472-0036-16	HP	MARGULIS, KEITH	0.00	8.00
29-2010	418092	IBUPROFEN CHILDREN'S 1	120	5	2	00904-5309-20	KMS	MARGULIS, KEITH	0.00	11.76
09-2010	418092	IBUPROFEN CHILDREN'S 1	120	5	1	00904-5309-20	KMS	MARGULIS, KEITH	0.00	11.76
09-2010	426521	CONCERTA 54MG TAB	30	30	0	50458-0587-01	KMS	MCGOLDRICK, PAT	0.00	175.85
13-2010	433589	CONCERTA 36MG TAB	180	90	0	50458-0586-01	KMS	WOLF, STEVERT M	0.00	953.84
14-2010	418092	IBUPROFEN CHILDREN'S 1	120	5	0	00904-5309-20	KMS	MARGULIS, KEITH	0.00	11.76
29-2011	442673	IBUPROFEN 200 MG TABL	60	7	0	00904-7915-40	KMS	FRANCIS, MITZIE *	0.00	3.88
29-2011	442675	CHLORHEXIDINE GLUC OR	473	16	0	00116-2001-16	KMS	FRANCIS, MITZIE *	0.00	8.00
31-2011	456371	APAP W/COD ELIXIR	120	7	1	00121-0504-16	KMS	FONJU, PAMELA	0.00	6.53
09-2011	458461	CONCERTA 36MG TAB	60	30	0	50458-0586-01	KMS	WOLF, STEVENMA	0.00	351.64
11-2011	458801	IBUPROFEN 400 MG TAB	60	15	2	55111-0682-05	KMS	ALCOTT, LISA	0.00	6.57
25-2011	458801	IBUPROFEN 400 MG TAB	60	15	1	55111-0682-05	KMS	ALCOTT, LISA	0.00	6.57
28-2011	462499	FERROUS SULFATE 325 M	30	30	5	00677-0071-10	KMS	RIVLIN, KENNETH	0.00	0.65
28-2011	462501	APAP W/COD ELIXIR	240	6	0	00121-0504-16	KMS	RIVLIN, KENNETH	0.00	8.56
24-2011	468561	CONCERTA 36MG TAB	60	30	0	50458-0586-01	KMS	WOLF, STEVERT M	0.00	351.64
29-2011	458801	IBUPROFEN 400 MG TAB	60	15	0	55111-0682-05	BAN	ALCOTT, LISA	0.00	6.57
29-2011	462499	FERROUS SULFATE 325 M	30	30	4	00677-0071-10	BAN	RIVLIN, KENNETH	0.00	0.65
30-2011	456371	APAP W/COD ELIXIR	120	7	0	00121-0504-16	BAN	FONJU, PAMELA	0.00	5.90

(continued on next page)

**LEROY PHARMACY II, LLC**

245 EAST 198TH STREET BRONX, NY 10458

Phone : 718-220-7600 Fax : 718-220-7618

**Patient Profile**

Date Range: 1/1/2008 - 6/13/2012

Page 2 of 2

Name : ~~S. S.~~  
 Address : 285 EAST 203RD 3 BRONX, NY 10458  
 Phone # : 718-220-1518 DOB : ~~02-02-1999~~  
 Allergy : No Known Allergies

I certify that this form is correct and I have received the drugs below.

X

Date	Rx #	Drug Name	Quantity	Days	Ref	NDC #	RPh	Prescriber Name	Patient Paid	Total
08-2011	462499	FERROUS SULFATE 325 M	30	30	3	00677-0071-10	KMS	RIVLIN, KENNETH	0.00	0.65
08-2011	472405	GEN CONCERTA 36MG TA	60	30	0	00591-2717-01	KMS	WOLF, STEVENMA	0.00	285.09
01-2011	462499	FERROUS SULFATE 325 M	30	30	2	00677-0071-10	KMS	RIVLIN, KENNETH	0.00	0.65
01-2011	481854	GEN CONCERTA 36MG TA	60	30	0	00591-2717-01	KMS	WOLF, STEVENMA	0.00	285.09
12-2011	462499	FERROUS SULFATE 325 M	30	30	1	00677-0071-10	KMS	RIVLIN, KENNETH	0.00	0.65
12-2011	489708	GEN CONCERTA 36MG TA	60	30	0	00591-2717-01	KMS	WOLF, STEVENMA	0.00	284.09
08-2011	497652	GEN CONCERTA 36MG TA	60	30	0	00591-2717-01	KS	WOLF, STEVENMA	0.00	322.08
07-2011	506142	GEN CONCERTA 36MG TA	60	30	0	00591-2717-01	KMS	WOLF, STEVENMA	0.00	0.00
03-2012	523084	VYVANSE 60 MG CAPSULE	30	30	0	59417-0106-10	KMS	MCGOLDRICK, PAT	0.00	162.34
01-2012	531347	VYVANSE 60 MG CAPSULE	30	30	0	59417-0106-10	KS	MCGOLDRICK, PAT	0.00	162.34
04-2012	543042	VYVANSE 60 MG CAPSULE	30	30	0	59417-0106-10	KMS	MCGOLDRICK, PAT	0.00	162.34
Prescriptions on this Report									Totals :	0.00 7,230.85